GUARDIAN®

APPLICATION AND ELECTION FORM –
PREMIUM & FLEXIBLE SPENDING ACCOUNT PLAN

FlexPlan

Employer Name _____ Guardian Group Policy Number G-_____

Location _____

Employee Name _____ Employee Date of Birth _____/_____/_____

Dependent(s) Name _____ Dependent(s) Date of Birth _____/_____/_____

_____ _____/_____/_____

Employee's Home Address _____

City State Zip Code

Employee's E-mail Address _____

Employee's Social Security Number _____ Date of Hire _____/_____/_____

Employee's Annual Salary _____ Payroll Frequency _____

Effective Date of Payroll Change _____ Eff. Date of Benefit Options _____

I hereby elect to participate in my Employer's Flexible Benefit Plan for benefits made available under Internal Revenue Code Sections 79, 105, 106, 125, and 129 as amended from time to time. As a participant in the Plan, I understand that I may redirect a portion of my pay to provide benefits under the Plan and that all such benefits will be paid with pre-tax dollars. I also understand that this is an irrevocable election for the Plan Year unless I have a qualified status change.

My employer is hereby authorized to redirect my compensation in such an amount as needed to provide for my benefit selection under any group term life insurance up to $50,000, medical, dental, vision, disability or other qualified programs offered by my Employer. In addition, my Employer is hereby authorized to redirect my compensation amounts indicated below to provide for my benefit selections under the Health Care Reimbursement Account and/or the Dependent Care Reimbursement Account.

Benefit Option	Employee Contribution Per Pay Period	Number of Pay Periods Per Year	Employer Contribution Per Pay Period
Insurance Premium			
☐ Medical Insurance Premium	$_____	_____	$_____
☐ Dental Premium	$_____	_____	$_____
☐ Other _____	$_____	_____	$_____
☐ Other _____	$_____	_____	$_____

Reimbursement Accounts	Employee Contribution Per Pay Period	Number of Pay Periods Per Year	Employee Annual Election
☐ Health Care Reimbursement Account (1) (FSA) (1) cannot exceed the annual dollar limit stated in the Plan Document	$_____	_____	$_____
☐ Dependent Care Assistance Plan (2) (3) (FSA) (2) cannot exceed $5,000 annually ($2,500 if married and filing separately) (3) cannot exceed the lesser of your earned income or the earned income of your spouse	$_____	_____	$_____

I understand that I will receive reimbursement from the Reimbursement Accounts when I provide my Employer or the Plan Administrator with the required information. I also understand that I can change my elections each year at the beginning of the Plan Year, and if I do not make a change at that time, my Insurance Premium election will remain the same for the new Plan Year and my Reimbursement Account election will cease as of the last day of the current Plan Year. If I terminate employment, I understand that the Plan Document will control any continued participation under this Plan. I understand that by participating in the Plan my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed.

In the event of my death, my designated beneficiary may have certain obligations and responsibilities to file claims and seek the payment of benefits under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

_____ _____

Beneficiary Relationship

Decline Participation: ☐ The Benefits of the Plan have been thoroughly explained to me and I decline to participate in all benefit options.

X_____ _____

Employee Signature Date

X_____ _____

Representative's Signature Date

Date Processed _____ Initials _____

Employee: Submit this form to your employer and keep a copy for your records
Employer: Send this form to the Guardian FlexPlan, P.O. Box 26290, Lehigh Valley, PA 18002-6290 and keep a copy for your records.

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COMPLETING AN APPLICATION AND ELECTION FORM FOR
PREMIUM AND FLEXIBLE SPENDING ACCOUNTS

- EMPLOYER NAME
- GUARDIAN GROUP POLICY NUMBER - Guardian six digit number assigned to plan.
- LOCATION - If affiliate or company has other localities.
- EMPLOYEE NAME
- EMPLOYEE DATE OF BIRTH
- DEPENDENT(S) NAME
- DEPENDENT(S) DATE OF BIRTH
- EMPLOYEE'S HOME ADDRESS - Please complete this in its entirety, street address, city, state, zip code.
- EMPLOYEE'S E-MAIL ADDRESS
- EMPLOYEE'S SOCIAL SECURITY NUMBER
- DATE OF HIRE
- EMPLOYEE'S ANNUAL SALARY
- PAYROLL FREQUENCY - Ex. Semi-monthly, weekly, etc.
- EFFECTIVE DATE OF PAYROLL CHANGE - What paycheck will the first deduction take place.
- EFFECTIVE DATE OF BENEFIT OPTIONS - Date coverage became effective under the plan.

BENEFIT OPTION

INSURANCE PREMIUM

- EMPLOYEE CONTRIBUTION PER PAY PERIOD - This is the per paycheck dollar amount, not total election.
- NUMBER OF PAY PERIODS PER YEAR
- EMPLOYER CONTRIBUTION PER PAY PERIOD - Again, per paycheck dollar amount, not total. If this differs from the employee contribution, please specify. (i.e.: Monthly, Semi Monthly, Annually)
- OTHER - this would include VISION, DENTAL PREM., CANCER PLANS. PLEASE SPECIFY THE PLAN OR PREMIUM NAME.

REIMBURSEMENT ACCOUNTS

- EMPLOYEE CONTRIBUTION PER PAY PERIOD - This is the per paycheck dollar amount, not total election.
- NUMBER OF PAY PERIODS PER YEAR
- EMPLOYEE ANNUAL ELECTION - Annual contribution to Spending Account for the Plan Year.

- **DECLINE PARTICIPATION IN FLEXIBLE BENEFIT PLAN - THIS IS TO BE CHECKED OFF, IF THE EMPLOYEE DECLINES PARTICIPATION IN THE ENTIRE PLAN, NOT JUST THE HEALTH CARE REIMBURSMENT OR DEPENDENT CARE ACCOUNTS.**

- EMPLOYEE SIGNATURE AND DATE - This must be signed by the employee!